National Service Frameworks: promoting the public health

In 1998 the Journal of Epidemiology and Community Health argued that the new millennium requires a journal of the times bringing together the strands of public health—the science and art, policy and practice. At around the same time the Department of Health for England announced the National Service Framework (NSF) programme, a programme to transform the way services are delivered for patients by the National Health Service and its partners. NSFs draw on the best of public health art and science—developing, implementing and evaluating practical policies to improve health and health services.

**English national policy context**

The NHS Plan sets out the main national priorities for the health service in England. Patients should have fair access and high standards of care wherever they live. At national level the Department of Health will, with the help of leading clinicians, managers, patients and carers, and partner organisations, set national standards in the priority areas. NSFs covering mental health and coronary heart disease have already been published. The National Cancer Plan was published in September 2000. An NSF for older people and one for diabetes will be published in 2001. These five NSFs between them cover around half of total NHS spending. Further NSFs will be developed on a rolling basis over the 10 year period of the NHS Plan. The government has announced that the next NSFs in the programme will be renal services, children’s services and for long term health conditions, focusing on neurological conditions.

*Saving lives: our healthier nation* set out the government’s plan to improve health and reduce health inequalities. It focused on cancer, coronary heart disease and stroke, accidents and mental health, the major causes of premature mortality, morbidity and disability.

The new NHS and *A first class service* introduced NSFs as models of public health service provision. Each NSF sets out the government’s vision to improve people’s health, the evidence base for effective interventions, public health measures, the service models required to deliver them, and the timescales against which progress will be monitored. Each NSF is developed with an explicit focus on implementation and delivery, to be driven locally with national support through a series of underpinning programmes, including finance, workforce development and information systems. They will require fundamental and sustainable change, and include performance measures and early milestones against which early progress will be monitored.

The strategic importance of the NSFs is recognised in the planning guidance issued to health and social services.

**Mental health**

The World Health Report 1999 shows that neuro psychiatric conditions are the commonest worldwide cause of premature death and years of life lost with disability—10% of the burden in low and middle income countries, 23% in high income countries. Besides the immense costs to individuals and their families, mental illness costs in the region of £32 billion per annum in England, including almost £12 billion in lost employment and approaching £8 billion in benefits payments.

The NSF for mental health sets out seven evidence-based standards, providing a blueprint to improve mental health and reduce inequalities, and to provide faster, fairer services. The standards cover mental health promotion; primary mental health care; services for people with severe mental illness; carers; and suicide prevention, where the national target is a reduction of at least one fifth by 2010.

**Coronary heart disease**

Coronary heart disease (CHD) is a major cause of premature death and ill health in this country, accounting for over 110 000 deaths per annum in England. The effects of this disease are not borne equally across society. For example, unskilled men are over 50% more likely than average to die of CHD, and Asian communities are at greater risk of both coronary heart disease and stroke. Moreover, despite the considerable evidence base for effective treatments for CHD, the evidence is incompletely and variably applied.

The NSF for CHD was published this year and sets a radical 10 year programme with 12 standards covering health promotion; risk reduction; treatment of acute myocardial infarction; rehabilitation; secondary prevention; and revascularisation. Long term change is balanced by a number of early priorities to be delivered within the next three years. Implementation of the NSF will play a key part in achieving the target of a 40% reduction in deaths attributable to CHD and stroke in people aged up to 75 years by 2010, saving some 200 000 lives.

**Older people**

People are living longer and healthier lives. Life expectancy is now 80 years for women and 75 years for men. But living longer is not enough; people want to enjoy their extra years as healthy active years. At present a man can expect on average 15 years of longstanding illness or disability, and a woman 17 years.

Moreover, there is anecdotal evidence of ageism, with allegations that older people are denied health care on the basis of age rather than clinical need. The government is committed to ending any such discrimination. And, similarly, to tackle concerns that older people do not always receive the quality of care that they require.

The NSF for older people, due to be published in 2001, will set standards and identify service models for health services for older people, with a specific focus on stroke, mental health, and falls/mobility.

**Diabetes**

Diabetes, as well as being a serious debilitating condition in its own right, can increase the risk of developing other illnesses including heart disease, renal disease, blindness and foot problems leading to amputation. On average, life expectancy for people with type 1 diabetes is reduced by 25% for both men and women. For those with type 2 diabetes, life expectancy is 5–10 years less than the
average.\textsuperscript{16} Studies like the recently published Audit Commission report \textit{Testing times}\textsuperscript{17} suggest that the quality of service for those with diabetes varies. If treatment is delivered ineffectively, the cost in terms of quality of life for the patient is significant.

The cost of diabetes to the NHS is significant, although difficult to quantify precisely, because of the range of complications. Various studies have suggested that diabetes accounts for 5\%\textendash{}10\% of all health care spending. The acute sector NHS costs for each person with diabetes are almost seven times greater than those for a person without diabetes. People with diabetes are relatively heavy users of hospital beds—around 10\% of total bed days.\textsuperscript{15} They are twice as likely to be admitted to hospital, and, once admitted, have a length of stay that is twice the average.\textsuperscript{18}

The prevalence of type 2 diabetes is increasing, partly because the population is aging, but also because of the greater prevalence of risk factors such as obesity. An increasing prevalence of childhood diabetes is contributing to this.\textsuperscript{19} Diabetes is particularly prevalent in people of South Asian, black African and black Caribbean origin.

The aims of the NSF for diabetes are to improve health outcomes for people with diabetes, and to raise service quality overall, reducing variations between services. The NSF will be published in 2001 for implementation from April 2002.

Implementation and delivery

NSFs are developed with implementation and service change in mind throughout, recognising that successful local delivery will require national support, that service development must be underpinned by organisational, professional and personal development, and that progress must be rigorously monitored.

For mental health, the first NSF to be published, an Implementation Board was established pre-publication. With the publication of the NHS Plan, Taskforces have been established for each of the priority areas. These will ensure that the targets in the Plan are delivered, adding value by identifying and unblocking the most complex implementation problems. Each of the clinical Taskforces (for cancer, CHD, mental health and older people) are chaired by the relevant national clinical director

Conclusion

NSFs show the impact that a public health model can have in policy development. The art of public health is reflected in the inclusive process that captures the range of views—patients, users and carers alongside clinicians, practitioners, academics, managers and partner organisations. The science is reflected in the reasoned way that aspirations and values are embodied in a set of evidence-based standards, service models and interventions, backed up by a practical programme of change with challenging but achievable milestones and goals.

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